INDIVIDUAL HEALTH CHECKLIST
(Health Benefit Plan)

( ) Review with General Health Insurance Policy Checklist
( ) Review with Checklist for Internal/External Grievance and Appeals

Mandatory Provisions/Benefits

The following provisions must be included in the individual policies. If they do not appear, check the statute to be sure it applies to the type policy being reviewed. See KRS 304.17-300 as a general reference.

( ) KRS 304.17-030(1)	Entire money and other considerations
( ) KRS 304.17-030(2)	Date and duration
( ) KRS 304.17-030(3)	Insure only one person unless family policy
( ) KRS 304.17-030(4)	No undue prominence to any portion of text
( ) KRS 304.17-030(5)	Exceptions and reductions specified
( ) KRS 304.17-030(6)	Form number in the lower left hand corner of the first page
( ) KRS 304.17A-139(1)	Newborn children covered from moment of birth.
( ) KRS 304.17A-139(2)	Requires automatic newborn coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
( ) KRS 304.17A-139(3)	Notice of birth & premium payment may be required within 31 days of birth in order to continue coverage, if payment of specific premium or fee is required to add a child.
( ) KRS 304.17A-140	Dependent includes legally adopted/court appointed guardian if coverage is obtained within 30 days of petition or appointment.
( ) KRS 304.17-050	Entire contract
( ) KRS 304.17-060	Limitation on defenses and incontestability (3 years)
( ) KRS 304.17-070	Grace period
( ) KRS 304.17-080	Reinstatement
( ) KRS 304.17-090	Notice of claim (60 days)
( ) KRS 304.17-100	Claim forms (15 days)

( )	KRS 304.17-110	Proof of loss (90 days)
( )	KRS 304.17-120	Time of payment of claims (30 days)
( )	KRS 304.17-130	Payment of claims at the insured's death
( )	KRS 304.17-140	Physical examination and autopsy
( )	KRS 304.17A-580(2)	Emergency medical condition definition: Prudent lay person rule and must be based on presenting symptoms.
( )	KRS 304.17A-510(1)(d)	A statement regarding the effect on the enrollee of any hold harmless agreements with providers must be included in the policy. Description of and limitation to enrollee liability.
( )	KRS 304.17A-138	Requires coverage for telehealth services
( )	KRS 304.17-150	Legal actions (60 days to 3 years)
( )	KRS 304.17-160	Change of beneficiary
( )	KRS 304.17-170	Right to examine and return policy (10 days) (Must be on face page)
( )	KRS 304.17-270	Right to refuse renewal
( )	KRS 304.17A-095(4)	Guaranteed rate for 12 months
( )	KRS 304.17A-005(8)(a)	Define prior creditable coverage
( )	KRS 304.17A-005(11)	Define eligible individual (18-month previous coverage without a 63-day lapse in coverage
( )	KRS 304.17A-250(7) 806 KAR 18:030	Health benefit plans must coordinate benefits. Must use benefit reserve.
( )	KRS 304.17A-250(6)	Hospice coverage must be provided at least equal to the benefits provided by Medicare (exempt for HSAs)
( )	KRS 304.17A-257	Mandated coverage for Colorectal cancer detection
( )	KRS 304.17A-145	Maternity coverage, hospital stay requirement
( )	KRS 304.17A-230	(1) Pre-existing conditions may not be imposed on eligible individuals (2) Must credit prior coverage when pre-existing conditions are imposed for non-eligible individuals

(3) Genetic information may not be treated as a pre-existing condition
(4) Pregnancy may be considered a pre-existing condition

( ) KRS 304.17A-155 — Domestic violence cannot be considered a pre-existing condition.

( ) KRS 304.17A-220(2) — Six-month look-back and 12-month pre-existing condition clause if pre-existing conditions exclusion is used

( ) KRS 304.17A-220(8)(a)(b) — No pre-existing condition exclusion for newborn, dependents, or guardians if coverage is applied for within 31 days of eligibility.

( ) KRS 304.17A-258 — Coverage must be provided for therapeutic food, formulas, supplements, and low-protein modified food products for treatment of **inborn errors of metabolism or genetic disorders** if prescription drugs are covered. Benefits will have a cap of $25,000 per year for therapeutic food, formulas, and supplements. Low-protein modified foods will have a separate cap of $4,000 per year. **Each cap shall be subject to annual inflation adjustments based on the Consumer Price Index (CPI).**

( ) KRS 304.17A-240(2) — Guaranteed renewal of health benefit plans:
(a) non-payment of premiums;
(b) fraud or intentional misrepresentation of material fact;
(c) intentional and abusive non-compliance with plan rules;
(d) the insurer ceases to offer coverage in the individual market
(e) the insured no longer works, resides or lives within the service area when a network is used
(f) insurance is through an association and the insured is longer a member of the association

( ) KRS 304.17A-245 — <u>Cancellation Requirements</u>:
(1) Requires 30 days' advance written notice of cancellation;
(2) Cancellation for non payment of premium effective to last day thru which premium was paid;
(6) The coverage continues if 30 days' notice is not provided;

( ) KRS 304.17-415 — Return of unearned portion of premium paid

( ) KRS 304.17A-240(3) — Notice of Discontinuation of coverage:
(a) When the insurer discontinues a particular plan;
1. Insurer must provide 90 days' notice of discontinuance.
2. Insurer must offer to each insured with coverage of this type the option to purchase any other type of plan offered by the carrier.

3. When discontinuing coverage, the insurer must act without regard to health status.

(b) 1. When the insurer discontinues offering all health benefit plans;
   a. Insurer must notify the commissioner and all insureds at least 180 days prior to discontinuance.
   b. All health benefit plans must be discontinued and non-renewed.
2. Insurer cannot enter the market for five (5) years.

( ) KRS 304.17A-500	Definitions: (3) covered person (4) coverage for emergency medical condition (6) grievance (8) insurer (12) record (15) utilization management
( ) KRS 304.17A-540	Limits and treatment, procedures, drugs or devices to be defined and disclosed in the policy or certificate and standards for claim denial letters
( ) KRS 304.17A-131	Mandated coverage for cochlear implants
( ) KRS 304.17A-143	Mandated coverage for autism ($500 monthly benefit)
( ) KRS 304.17A-148	Mandated coverage for diabetes
( ) KRS 304.17A-135	Autologous bone marrow transplantation (ABMT) for breast cancer
( ) KRS 304.17-316	Coverage for low-dose mammography screening
( ) KRS 304.17-316(2)(b)	Requires coverage for mammograms, regardless of age, for a covered person diagnosed with breast disease.
( ) KRS 304.17A-500(4)	Insurers cannot have language that conflicts or is more restrictive than this section allows. Definition of emergency medical condition.
( ) KRS 304.17A-643(2)	Special circumstances when the insured can have continued care with a same provider even though the provider is no longer participating. Treating provider must make the request with concurrence with the covered person. (Must inform insureds of when they can have continuity of care)
( ) KRS 304.17A-647(2)	A female may be covered for an annual Pap smear performed by an obstetrician or gynecologist without a referral from a PCP.

( ) KRS 304.17A-520	Managed care plan shall provide access to a consultation with a participating provider for a second opinion.
( ) KRS 304.17A-535(4)	Must have an exception policy for plans that use a formulary. (managed care plan)
( ) KRS 304.17A-505(j)	Must make available upon request a complete formulary.
( ) KRS 304.17A-165	Override provision for refill of drug prior to expiration of supply

The following must be covered. If not specifically mentioned as a benefit, they may not be excluded.

( ) KRS 441.052	Coverage for incarcerated persons
( ) KRS 304.14-370	Binding arbitration cannot be required. Arbitration can be an option.
( ) KRS 304.17A-702	Payment of claims requirements
( ) KRS 304.17A-005(19)	Providers defined (in addition to the ones listed below) pharmacists, podiatrists, physician's assistant, nurse practitioner, and other practitioners as determined by the department by administrative regulation in 13A.
( ) KRS 304.17A-505	Disclosure of covered services, restrictions or limitations, financial responsibility of covered person, prior authorization requirements or any review requirements with respect to covered services, where and how services may be obtained, changes in covered services, covered persons' right to appeal, procedures for appeal and measures to ensure confidentiality of the relationship between an enrollee and a health care provider
( ) KRS 304.17-305	Indemnity payable for services performed by optometrists, osteopaths, physicians, chiropractors or podiatrists
( ) KRS 304.17A-175	Co-payment/co-insurance for optometrist or chiropractor same as physician or osteopath
( ) KRS 304.17-3185	Coverage of services for licensed psychologists or licensed clinical social workers
( ) KRS 304.17-315	Policy covering services performed by dentists
( ) KRS 304.17-317	Ambulatory surgical centers (Must be covered)
( ) KRS 304.17-319	Coverage for TMJ

( ) KRS 304.12-013	Coverage for AIDS
( ) KRS 304.17A-146	Benefits must be provided for a registered nurse first assistant if first assistance benefits are provided, provided they are acting within the scope of their license
( ) KRS 304.17A-1473	Coverage must be provided for services of a physician assistant if coverage is provided for surgical first assisting or intraoperative surgical care benefits or services.
( ) KRS 304.17A-641(1)	An insurer that requires prior authorization for post-stabilization treatment in an emergency care situation at a non participating hospital, approval or denial shall be provided in a timely manner, but in no case to exceed two hours from the time request has been made and all relevant information provided. Failure to provide timely approval shall constitute approval.
( ) KRS 304.17A-645	A PCP treating a person with a chronic, disabling, congenital, or life threatening condition may authorize a referral to a participating non PCP specialist, up to 12 months or for the contract period, whichever is shorter.
( ) KRS 304.17A-647	Insurers cannot prohibit a PCP from referring a covered person who is pregnant or has a chronic gynecological condition to authorize a referral to a participating obstetrician or gynecologist for up to 12 months or for the contract period, whichever is shorter.
( ) KRS 304.17A-149	Requires coverage for payment of anesthesia & hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions, persons with significant behavioral problems, in all health benefit plans that provide coverage for general anesthesia & hospitalization services.
( ) KRS 304.17A-132	Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.

Optional Provisions

The following provisions may be included. See KRS 304.17-300 as a general reference.

( ) KRS 304.17-190	Change of occupation
( ) KRS 304.17-200	Misstatement of age
( ) KRS 304.17-210	Other insurance in this insurer

( ) KRS 304.17-220 Insurance with other insurers
( ) KRS 304.17-230

( ) KRS 304.17-240 Relation of earnings to insurance

( ) KRS 304.17-250 Unpaid premium

( ) KRS 304.17-260 Conformity with state statutes

( ) KRS 304.17-280 Illegal occupation

( ) KRS 304.17-290 Use of intoxicants

( ) KRS 304.14-230(1) The policy may be delivered by electronic transfer, by agreement between the insurer and the insured or the person entitled to receive the policy.

( ) 806 KAR17:030 Indemnification for surgical care by use of a schedule:

a. If indemnification is limited to the listed operations, the policy or rider shall so indicate in the unequivocal language.

b. If the company is to determine the amount to be paid for any unlisted operation, the policy must provide how that amount will be determined.

Required Offerings

( ) KRS 304.17-185 Nursery care for well newborns

( ) KRS 304.17-310(1) Dependent coverage
( ) KRS 304.17-310(2) Continuing coverage for handicapped child
( ) KRS 304.17-310(3) Unmarried Dependent child coverage until 25 years of age

( ) KRS 304.17-313 Home health care (Must cover a minimum of 60 visits per year)

( ) KRS 304.17-318 Mental illness

( ) KRS 304.17A-135 Treatment of breast cancer

( ) KRS 304.17A-134 Breast reconstruction surgery treatment for endometriosis and
( ) KRS 304.17-3163 endometrisis, and bone density testing Mastectomy cannot be required on an outpatient basis.

Prohibited Provisions

( ) KRS 304.5-160 No health insurance contract shall cover abortion except by rider.

( ) KRS 304.12-250	May not exclude work-related conditions unless the claimant is eligible for benefits under any workers compensation.
( ) KRS 304.17-030(7)	Incorporation by reference of charter, rules, constitution, or by-laws of insured.
( ) KRS 304.17-360	Benefits or values for surviving or continuing policyholders contingent upon termination or lapse of other policyholders.
( ) 806 KAR 17:050	Limit or exclude obligation to pay because insured is eligible for or receiving Medicaid.

Requirements not necessarily in the policy;

( ) KRS 304.17A-220(9)	Certification of prior coverage
( ) KRS 304.17A-607, Section 1(h)(i)	Timeframes for UR decisions
( ) KRS 304.17A-150	* Anyone marketing insurance cannot encourage any consumer not to file an application for health insurance with another carrier because of health status. * Insurers cannot encourage any consumer to apply for health insurance with another carrier because of health status. * Insurers cannot encourage an employer to exclude an employee from coverage. * Insurers are prohibited from compensating any person marketing insurance on the basis of health status. * Insurers must compute the insured's coinsurance or cost sharing on the basis of the amount received by a healthcare provider from the insurer.

For PPO plans see PPO checklist
Also applies to HMOs